RENJEN ORTHODONTICS
generations of smiles created

ADULT PATIENT INFORMATION

(All information will be kept completely confidential)

Name: Ms. / Dr. / Mr. / Mrs. ______________________________ I prefer to be called: ____________ Sex: M F
First Last

Address: ______________________ City: ______________ State ______________
Zip: ________ Home phone: ____________ Cell phone: ____________ Birthdate: ____________
Email: ______________________________ Preferred Contact Method ____________

Employer: ______________________________ Bus. Phone: ______________
Spouse's Name: ______________ Employer: ____________ Bus. Phone: ____________
First Last

Marital Status: Single Married Divorced Separated Widow(er)

If another person will be responsible for payment of this account, please complete the following:
Name: ____
Address: ______________________ City: ______________ State ______________
Zip: ________ Home Phone: ______________ Age: ________ Birthdate: ______________
Employer: ______________________________ Bus. Phone: ______________

How did you hear about our Office? ______________________________
Whom may we thank for your referral? ______________________________
Please describe your problem and/or concerns:
____
____

DENTAL HISTORY

Name of General Dentist: ______________
(Circle appropriate information)
Frequency of dental checkups: Twice a year / Once a year / only if a problem arises / Never
Date of last cleaning: ______________
Is there any unfinished care to be completed with your dentist? No Yes
Explain: ______________________________
Do you need Antibiotics for dental visits or cleanings? No Yes
Explain: ______________________________
Have you had any Facial or Dental injuries? No Yes
Explain: ______________________________
Have you ever had Periodontal (Gum) disease? No Yes
Explain: ______________________________
Do your gums bleed when you brush? No Yes
Have you ever consulted an Orthodontist previously? No Yes
When: ______________________________
Do you feel you have a “gummy” smile? No Yes
Explain: ______________________________
Please circle if there is a history of:
Clenching teeth Jaw joint clicking Jaw joint soreness Jaw joint popping Grinding teeth

Ringing in the ears Frequent Headaches Muscular soreness around head & neck Facial Trauma
Speech problems (if so, which sounds) ______________ Mouth Breathing while: Awake Asleep
Is there any other information that may be helpful?
____
____

Please Turn Over

Your answers to the following questions will help us with selecting the safest and most effective means of providing your Orthodontic care. All information will be kept strictly confidential.

MEDICAL HISTORY

Physician's Name: ____ Last Visit: ______________________________

Allergic to Latex or Nickel (costume jewelry)?	No	Yes
Explain: ______________________________		
Any change in your general health recently?	No	Yes
Explain: ______________________________		
Are you currently taking medications?	No	Yes
List Drugs: ______________________________		
Do you have Osteoporosis or other bone disorders?	No	Yes
Explain: ______________________________		
Have you ever taken any osteoporosis medications?	No	Yes
List: ______________________________		
Are you allergic to any medications?	No	Yes
List Drugs: ______________________________		
Have you ever been told not to give blood?	No	Yes
Explain: ______________________________		
Are you pregnant?	No	Yes
Due Date: ______________________________		
Have you ever had (or considered having) Facial Plastic Surgery of the nose, chin or jaws?	No	Yes
Explain: ______________________________		

Please circle if you have or previously had any of the following conditions:

Heart Murmur	No	Yes	Hepatitis	No	Yes	Mouth Breather	No	Yes
Heart Surgery	No	Yes	Diabetes	No	Yes	Frequent Headaches	No	Yes
Rheumatic Fever	No	Yes	Kidney Disease	No	Yes	Nervous/Anxious	No	Yes
Endocrine Disorders	No	Yes	Liver Disease	No	Yes	Cancer	No	Yes
Tuberculosis	No	Yes	Bone Disorders	No	Yes	HIV/AIDS	No	Yes
Growth Disorders	No	Yes	Blood Disease	No	Yes	Asthma	No	Yes
Epilepsy	No	Yes	Hives/Rash	No	Yes	Fainting	No	Yes

Any other health problems or special concerns: ______________________________

INSURANCE: To avoid misunderstandings regarding dental insurance, all professional services rendered are charged directly to the patient and the patient is responsible for payment of fees. We will prepare necessary forms or reports to help you obtain benefits from your insurance company. In order to do so, please sign below authorizing Renjen Orthodontics to provide each respective insurance company, claim administrator and consulting health care professional information concerning health care, advice, treatment, or supplies provided. This form also authorizes release of any information relating to a claim submitted on your behalf. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I have read and understand the above questions. If there are any future changes to my medical or dental status I will inform the Dr. and/or staff of Renjen Orthodontics. I certify the above information is correct.

Patient's Signature: ______________________________

Date: ______________________________

Primary Insurance Carrier______________________________ Secondary Insurance Carrier ______________________________

Subscriber ID #______________________________ Subscriber ID # ______________________________

Group ID #______________________________ Group ID # ______________________________

Social Security/ID #______________________________ Social Security/ID # ______________________________

Primary Insurance Holder______________________________ Secondary Insurance Holder ______________________________

Primary Insurance Holder DOB ______________________________ Secondary Insurance Holder DOB ______________________________